



## Authorization to Use and Disclose Protected Health Information

1. I am completing this form to allow the use and sharing of Protected Health Information about:

Printed Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

2. I authorize this person or organization: Knoxville Psychiatric Group, 201 N. Weisgarber Rd., P.O. Box 11425, Knoxville, TN, 37939

3. a. To use or disclose the following information:

Complete copy of the medical record

Outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse

Treatment plans

Social, family, educational, and vocational histories

Social work assessments and plans

Progress, case or similar notes

Information about how the patient's condition(s) affects or has affected his/her ability to work, and to complete tasks or activities of daily living

HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated here: DO NOT RELEASE THESE.

Other: \_\_\_\_\_

b. Dates of care included: From \_\_\_\_\_ to end of treatment

4. To my Primary Care Physician: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

5. The information will be used/disclosed for the following purposes: medication coordination, psychiatric and medical treatment and notification.

6. I understand and agree that this authorization will be valid and in effect until end of treatment. I understand that after that event, this information cannot be released unless I send a new authorization.

7. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of Knoxville Psychiatric Group who is to supply this information. This revocation will prevent any releases after the date it is received but can not change the fact that some information may have already been sent or shared before that date.

8. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed at #4 above, nor will it affect my eligibility for benefits.

9. I understand that I may inspect a copy of the health information described in this authorization

10. I affirm that I have a clear understanding of the contents and purpose of this form.

\_\_\_\_\_  
Signature of patient (or parent/legal guardian) Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name of patient (or parent/legal guardian)

Relationship to patient: \_\_\_\_\_

I acknowledge that I received a copy of this completed form

I, as a mental health professional, have discussed the issues above with the client and/or his/her personal representative. My observations of his/her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_  
Signature of professional Date: \_\_\_\_\_

\_\_\_\_\_  
Printed name professional